Marla Shapiro, Ph.D., Neuropsychologist
Independent Neuropsychology Consultants

PERMISSION TO RELEASE AND OBTAIN INFORMATION

My signature below indicates my permission for the following individuals to exchange, discuss and release information as requested to and with Dr. Marla Shapiro for purposes of providing evaluation or consultation services. This information may include educational records (including special education records), medical records, observations, correspondence, and test results, with raw data released only to appropriately trained professionals. Dr. Shapiro will release formal evaluation reports only to these individuals as indicated below. This permission is valid for 1 year from today, and can be revoked in writing at any time.

Client name ____ DOB __________________ Today's date_______________

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______________________________ ______________________________
Name (Parent/Guardian if under 18) Signature

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